BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

GLENN MINNEY
BVA DIRECTOR OF GOVERNMENT RELATIONS

BEFORE A JOINT SESSION OF THE HOUSE AND SENATE COMMITTEES ON VETERANS AFFAIRS

May 20, 2015

INTRODUCTION

Chairman Isakson, Chairman Miller, Ranking Members Blumenthal and Brown, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this invitation to present our legislative priorities for 2015. BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families.

MEDICAL ACCCESS TO REHAB ACT: S. 171 AND H.R. 288

Veterans who are currently ineligible (not service connected) for travel benefits under Title 38, Section 111 of U.S.C. are not covered for the cost of public transportation or personal travel expenses to one of the 13 Blind Rehabilitation Centers (BRCs), thus adding to the financial burdens of disabled, low-income veterans. Those who must currently shoulder this hardship, which often involves airfare, are discouraged by these costs. The average age of veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group. BVA urges that these travel costs be covered by the Veterans Integrated Service Network (VISN) from which the veteran is referred and that such costs not be an added burden for the catastrophically disabled blinded veteran in obtaining the crucial rehabilitation training needed to gain independence through a BRC. BVA therefore requests passage of legislation in the first session of the 114th Congress, ensuring that the Veterans Health Administration (VHA) cover such travel costs by changing Title 38, Section 111 to require VA to provide transportation costs by air, train, bus, or other methods. The legislation should specify that the transportation would be to a special rehabilitation program serving blinded veterans or the spinal cord injured and that it would be for either inpatient or HOPTEL program medical care.

BVA again thanks Senator Jon Tester for introducing S. 171 and also expresses appreciation to Congresswoman Julia Brownley for introducing H.R. 288, the companion House bill. The legislation would assist low-income and catastrophically disabled veterans by removing the financial burden and hardship of travel expenses needed to access vital care that improves independence and quality of life. BVA points out that at both the Senate VA Committee hearing May 9, 2013 and the House VA Subcommittee on Health hearing June 24, 2013, the VA witness, along with VSO witnesses, testified in favor of this legislation.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation services with high quality inpatient and outpatient specialized training, only to tell catastrophically disabled blinded or spinal cord injured veterans that they must pay their own travel expenses. To put this dilemma in perspective, a large number of our constituents are living below the poverty line. None, of course, can drive an automobile themselves. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as a rural resident or a highly rural resident. The data also points to the fact that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without financial assistance, the data found that for most health characteristics examined, enrolled rural and highly rural blinded veterans were similar to

the general population of enrolled veterans. The analysis also confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group.[1] In FY 2007, rural veterans had a median household income of $19,632, four percent lower than the household income of urban veterans ($20,400).[2] The median income of highly rural veterans showed a larger gap at $18,528, adding significant barriers to paying for air travel or other public transportation to enter a VA BRC or other rehabilitation program.

More than 70 percent of highly rural veterans have to drive more than four hours to receive tertiary care from VA. The FY 2015 VSO Independent Budget reports from current VA research that among all VA health care users, 36 percent (more than 2.2 million) reside in rural areas, including 76,955 from "highly rural areas" as defined by VA in 2012.

States and private agencies are not the answer either since they do not usually operate blind services in rural regions. In fact, almost all private blind outpatient agency services are located in large, urban cities, making them impossible to access for daily outpatient rehabilitation by rural, elderly blinded veterans needing training. The Department of Veterans Affairs Blind Rehabilitation program is also attached to a VA Medical Center, which allows the veteran to continue receiving any additional medical care while attending a VA BRC Program. With current economic problems that bring state budgets clearly into view, we expect further cuts to these social services. Such cuts would prohibit state agencies from funding disabled veteran travel to a VA blind center across state borders in other regions. If a low-income veteran needs blind rehabilitation training to learn the skills to live independently at home, the benefit of a $400 airline ticket to get to a BRC will far outweigh its cost to the nation. We again ask Congress to provide this small change in Beneficiary Travel/Access to Care eligibility and pass H.R. 288 and S. 171 before the end of this session.

DoD-VA VISION CENTER OF EXCELLENCE

As greater numbers of wounded members and veterans from Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), Operation New Dawn (OND), enroll in the VA health care system after 12 years of conflict in the Middle East, an increasing number of visually impaired veterans are being added to the current VHA database of the combat wounded from all previous wars.

The establishment of the DoD-VA Vision Center Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries (authorized by the Fiscal Year 2008 National Defense Authorization Act, Public Law 100-180, Section 1623) becomes even more vital as VHA records reveal that 184,728 OIF/OEF/OND veterans with eye conditions entered the VA system for care from October 2001 through September 30, 2014.[6]

The Hearing Center of Excellence (HCE) and the Extremity and Amputation Center of Excellence (EACE) were also mandated in the FY 2009 National Defense Authorization Act

(Public Law 110-417). HCE is aware of 255,000 individuals with hearing loss. Congress clearly established these three Centers of Excellence with the intention that they have joint leadership. Their purpose was to improve the care of wounded or injured service members and veterans affected by combat eye, hearing, and limb amputee trauma. The Centers should also improve clinical coordination between DoD and VA for the treatment of wounded service members suffering from these specialized kinds of injuries. These Centers are also tasked with developing joint clinical, bidirectional registries containing up-to-date information on the diagnosis and treatment of injuries, current activities in the areas of vision research, and the examination of long-term outcomes for these injuries. Unfortunately, these registries are still not fully functional even after being mandated more than four years ago. While VCE on the DoD side has already entered more than 27,000 of the eye-injured into the Defense and Veterans Eye Injury and Vision Registry (DVEIVR), VA has entered a total of 50 veterans' records! Worse, we found that VHA developed its own Military Veterans Eye Injury Registry (MVEIR) with contractors entering records into it and then sharing the data with DVEIR.

Despite a legislative mandate and Secretary William Gates' inclusion of these three Centers as a top priority back in the February 2010 Quadrennial Defense Report (QDR), bureaucratic problems, limited oversight, weak organizational structure, and limited VA budgets and staffing have all hindered significant progress toward the full establishment of the VCE, HCE, and EACE. DoD has been represented at VCE by ten other full-time staff members and another 88 DoD contracted individuals. VHA, on the other hand, now has a total of six full-time staff, which comes only as a result of Congressional oversight.

The DoD Armed Forces Surveillance Center report of May 2011, **Eye Injuries, Active Component, U.S. Armed Forces, 2000-2010**, found that during an 11-year surveillance period there were 186,555 eye injuries worldwide. However, no updated data reports on eye trauma have been published since 2011. The registry is also vital in ensuring access to the full continuum of VA Eye Care Services, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees have helped establish over the years.

BVA requests that this Committee hold hearings with senior witnesses from both the Navy Surgeon General's Office and senior VHA representatives to answer these questions and to explain the lack of resources and progress with VCE during the past four years.

INFORMATION ACCESSIBILITY OFFICER

As important as information security is to the Department of Veterans Affairs and the 22 million veterans VA serves, so is information accessibility. Within the blinded veteran community, access to numerous documents does not exist. Blind as well as elderly veterans must currently choose between their right to file a claim and their right to privacy. VA has implemented a paperless form filing process. This process is keeping veterans without computer technology or accessibility from having the same right to privacy as those with the technology. Without this technology a veteran much rely on another individual to access his/her private medical records and information. An Information Accessibility Officer would be a liaison between the 508 compliance officer, the veteran, the service officer, and the blind VA employee. This person would be responsible for ensuring that each and every veteran has access to and the necessary

knowledge to use VHA and VBA documents and websites. It is his responsibility also to educate the veteran on how to navigate VA websites and to point out to VA any and all boundaries that may limit veteran access to information. The only way to ensure that all blinded and elderly veterans, as well as those with technology barriers, have access to their records is to require each VA Medical Center and VBA Regional Office to have an Information Accessibility Officer.

DEFENSE VISION TRAUMA RESEARCH PROGRAM FOR FY 2016

Vision Injuries Warrant New and Additional Research

BVA, along with other Veterans Service Organizations, is again supporting the programmatic request to continue directed funding in FY 2015 for the Vision Trauma Research Program (VTRP) within Peer Reviewed Medical Research (PRMR) for the extramural translational battlefield vision research line item. The request is for an increase to $15 million for FY 2016.

The Peer Reviewed Vision Research Program (VRP) in Defense Appropriations funds extramural vision research into deployment-related vision trauma that is not currently conducted by VA nor elsewhere within DoD (including the joint DoD/VA Vision Center of Excellence) or the National Eye Institute within the National Institutes of Health. The National Association for Eye and Vision Research is urging Congress to fund the VRP at $15 million in FY 2016. Although former Secretary of Defense Gates identified restoration of sight and eye care as one of four top priorities for deployment-related health research funding (Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD), and Prosthetics being the other three), DoD has not yet established "core" funding to address all vision research gaps. VRP funding, therefore, is urgently needed.

Today, battlefield conditions have resulted in a high percentage of penetrating eye injuries and TBI-related visual system dysfunction among those wounded/evacuated due to Improvised Explosive Device (IED) blast forces. With the continued presence of the U.S. in Afghanistan, coupled with other global threats, eye injuries will continue to be a challenge. Serious combat eye trauma from OIF and OEF was the second most common injury and trails only hearing loss, according to an Office of VA Research and Development article published in October 2008. The article reported 4,970 moderate-to-severe penetrating combat eye injuries. The VHA Office of Public Health reported that from October 2001 until the end of the fourth quarter of FY 2014 (September 30, 2014), the total number of OIF and OEF veterans enrolled in VA was 130,340. Among those injuries were 12,473 retinal and choroid hemorrhage injuries (including retinal detachment), 3,144 optic nerve injuries, 8,162 corneal injuries, and 16,180 with traumatic cataracts. Additional relevant figures are as follow:

- A 2012 study using published data from 2000-2010 estimated that deployment-related eye injuries and blindness have cost the U.S. $2.3 billion a year, yielding a total of $25.1 billion, driven primarily by the present value of long-term benefits, lost wages, and family care.

- Traumatic eye injury from penetrating wounds and TBI-related visual disorders ranks second only to hearing loss as the most common injury among "active" military:

- Traumatic eye injuries have accounted for upwards of 16 percent of all injuries in OIF and OEF combat.
- Male soldiers age 20-24 account for 97 percent of visual injuries.
- Eye-injured soldiers have only a 20 percent return-to-duty rate as compared to an 80 percent rate for other battle trauma injuries.
- VCE reports 197,000 OEF/OIF veterans with eye injuries since 2000
- Upwards of 75 percent of all TBI patients experience short- or long-term visual disorders (double vision, light sensitivity, inability to read print, and other cognitive impairments).

• Ground soldiers face numerous assaults that potentially impair visual function, including:
- Eye injuries from chemical, biohazard, laser, and environmental exposure.
- Corneal (front-of-eye) and retinal (back-of-eye) injuries that are often not evaluated until a soldier's vital signs are first assessed and which, if not stabilized, lead to vision loss.
- Direct blast injuries as well as potential long-term ocular injuries from the blast wave.

• Since Congress first funded the VRP line in FY 2009 Defense Appropriations, DoD, with the U. S. Army Medical Research and Materiel Command as the execution management agency, has awarded 60 grants totaling $45 million to researchers addressing penetrating eye injuries, corneal healing, retinal/corneal protection, TBI-related visual dysfunction, the eye blast phenomenon, and vision rehabilitation.

Vision, the sense most critical for optimal military performance in battlefield and support positions, is vulnerable to acute and chronic injury. Research to effectively treat vision trauma and TBI-related visual disorders can have long-term implications for an individual's vision health, productivity, and quality of life for the remainder of military service and into civilian life.

DoD Limited in Funding Vision Trauma Research

In each VRP funding cycle, DoD reviews grant submissions for programmatic need–that is, it addresses specific gaps in Vision Trauma Research–as well as for scientific merit through the peer review process. As the field of vision trauma research grows, DoD can fund only a fraction of the grants with both scientific merit and program relevance. Limited funding is further illustrated as follows:

• In the combined FY 2009-2010 VRP funding cycle–the program's first year–120 pre-applications were received, 50 were invited to submit full proposals, and 12 projects were funded—for a total of $11 million.

• In the combined FY 2011-2012 VRP funding cycle, 151 pre-applications were received, 50 were invited to submit full proposals, and 21 projects were funded—for a total of $13.7 million.

• In the combined FY 2013-2014 VRP funding cycle (in process), 275 pre-applications were received and 151 were invited to submit full proposals. The number of applications awarded with FY 2013 funds is 22—for a total of $15 million. Another five applications have been awarded with FY 2014 funds—for a total of $5 million. Seven additional FY 2014 projects have been recommended for funding.

VRP Funding Yields Deliverables

VRP funds two types of awards: hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI; and translational research, which facilitates development of diagnostics, treatments, and therapies–especially those that can be employed on the battlefield to save vision.

Research projects funded by the first two VRP funding cycles (2009-2010 and 2011-2013) have resulted in 80 published papers that are advancing knowledge about the diagnosis and treatment of eye trauma injuries.

VRP funding has also supported the development of:

- A portable, hand-held device to analyze the pupil's reaction to light, enabling rapid diagnosis of TBI-related vision dysfunction.

- An "ocular patch," which is a nanotechnology-derived reversible glue that seals lacerations and perforations of the eye on the battlefield, protecting it while a soldier is transported to a more robust medical facility where trained ocular surgeons can properly suture the globe.

- A validated computational model of the human eye globe to investigate injury mechanisms of a primary blast wave from an IED, which has accounted for 70 percent of the blast injuries in Iraq and Afghanistan. The model determines the stresses on and deformations to the eye globe and surrounding supporting structures to enable DoD to develop more effective eye protection strategies.

- A vision enhancement system that uses modern mobile computing and wireless technology, coupled with novel computer vision (that is, object recognition programs) and human-computer interfacing strategies, to assist visually impaired veterans undergoing vision rehabilitation to navigate, find objects of interest, and interact with people.

DoD-VA HEARING CENTER OF EXCELLENCE (HCE)

During present-day combat, a single exposure to the impulse noise of an IED can cause immediate noise-induced tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. At 140+ dBA (unit of measure for decibels), the sound pressure level of an IED, damage occurs instantaneously. Many common military operations and associated noise exceeding the 140 dBA threshold occur on the battlefield, making hearing loss and tinnitus the number one injury from the wars. According to the DoD Hearing Center of Excellence website, more than 335,000 OIF and OEF service members and veterans have been service connected for tinnitus and some 257,000 have various levels of documented hearing loss.[3]

[3] HCE.Gov DoD website data "Tinnitus and Hearing Loss, OIF and OEF."

Like VCE, the DoD-VA HCE also has limited military and full-time VA staff. Today there are three full-time VHA staff members at HCE. VHA has no programmatic line item funding for HCE despite statements by senior officials in 2013 that it would be provided. We point again to lack of governance from the DoD VHA Health Executive Council and Joint Executive Council. The Government Accountability Office Report 11-114 of January 31, 2011 found that while hearing loss is a major physical injury from the wars, progress on starting a joint hearing registry to track and develop coordinated care between the two systems lags far behind VCE.[4] The invisible wounds of hearing and visual impairments (sensory trauma research) do not seem to result in budgets equal to those for other injuries. Hearing deployment trauma research, for example, has had virtually no line item in the CDMRP for research. BVA again wishes to stress that more than 350,000 OIF/OEF/OND service members have reported tinnitus and more than 250,000 have reported hearing loss following their return from Iraq and Afghanistan. These numbers equal those reported for TBI, the signature injury of the two conflicts.

Translated into financial costs, VBA paid out approximately $1.39 billion in VA disability compensation for tinnitus in 2010. At the current rate of increase, service-connected disability payments to veterans with tinnitus will cost $2.26 billion annually by 2016. The government's investment in the Hearing Center of Excellence and hearing trauma defense research, which could perhaps prevent, reduce, or even cure hearing loss in the future, pales in comparison (less than one percent of current compensation payments combined).

VA INFORMATION TECHNOLOGY AND SECTION 508 ADA COMPLIANCE

Section 508 of the Americans with Disabilities Act requires federal agencies to ensure that all electronic and information technology developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public. The 2012 Department of Justice (DOJ) report identifies continued challenges with Section 508 implementation and management. The report makes recommendations for training, policy, and better collaboration. The DOJ Section 508 compliance survey completed in the summer of 2012, however, found widespread problems and lack of accessible electronic and information technology at federal sites.[5]

BVA has repeatedly requested in its annual resolutions that VA Information Technology be fully compliant with Section 508 and 504 of the Americans with Disabilities Act on VHA and VBA websites. We appreciate the fact that both of these committees have requested VA briefings and required updates on the status of its efforts to comply with 508 and 504 access. The following 508 and 504 compliance issues are areas of specific and recent concern:

- Inaccessible kiosks at VA Medical Centers for checking in for scheduled appointments.
- Inaccessible Telehealth tools, namely the Health Buddy home monitoring station.
- VBA webpages containing eBenefits information with access problems when screen readers are utilized.

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[4] "Hearing Loss Prevention: Improvements to DoD Hearing Conservation Programs Could Lead to Better Outcomes" GAO-11-114 January 31, 2011.

[5] www.ada.gov/508

Blind VA employees and BVA National Service Officers are frequently unable to access the current VHA and VBA systems because of its lack of ADA-compliant features. We request that Congress continue its strong oversight to ensure that VA will adequately fund its information technology programs and that it meet timelines for fixing the inaccessible websites. We are concerned about the lack of progress being made on compliance with certain information technology programs. There was $11.6 million in FY 2014 for 508 and 504 access program funding with contractor support added to fix these long-standing problems. We ask Members of Congress to continue strong oversight of the IT system and to insist that VA meet its obligations to comply with Section 508 and 504 in all Internet-based programs.

FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

Integrated among OIF and OEF veterans with eye injuries is an aging veteran population that can be characterized by a growing prevalence of age-related degenerative visual impairments. During FY 2012, there were 50,304 blinded veterans on permanent VIST Coordinator case management lists. VA research studies estimate that there are 132,000 legally blinded veterans. Epidemiological projections indicate that there are another 1.5 million low-vision veterans in the United States with visual acuity of 20/70 or worse. About 285,000 have glaucoma. VA currently operates 13 comprehensive residential BRCs across the country. BRCs still provide the ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. Unfortunately, however, the VISN networks and medical center directors at some sites are claiming that there is no funding for retiring staff members or for those who transfer to another facility. Some BRCs are therefore lacking the staffing to help blinded veterans acquire the essential adaptive skills to overcome the many social and physical challenges of blindness.

BVA recommends that the VHA BRS Director be given VHA central control over the blind centers, personnel resources, and funding levels. BVA would like the Congressional Oversight Subcommittee to ask where the BRS funding is being used. VHA and VISNs must explain funding allocations to BRCs. These centers need directed funding to bring staffing levels up to required levels. Directors should not be allowed to divert funds designated by the Veterans Equitable Resource Allocation (VERA) System for rehabilitation admissions from the blind centers to other general medical operations. There should be no bed closings or hiring freezes on critical blind center staff positions. VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of Public Law 104-262.

The Visual Impairment Service Team (VIST) structure now employs 123 full-time Coordinators and 38 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. There are also 81 full-time Blind Rehabilitation Outpatient Specialists (BROS). BVA believes and has long maintained that any VA facility with 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA and other endorsers of the VSO Independent Budget for FY 2016 assert that in order to strengthen the ability of VHA to recruit and retain VHA health care professionals, they must have access to Continuing Medical Education conferences and updates on emerging research and professional development education to meet licensure and certification standards.

Private agencies for the blind lack the necessary full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy, and radiology support services. Also, most private agencies are all outpatient centers in major cities that cannot be accessed by our rural blinded veterans. In many rural states there are no private inpatient blind training centers, leaving the VA BRCs as the only option.

BVA requests that the Department of Veterans Affairs ensure that all private agencies be required to demonstrate the peer reviewed quality outcome measurements that are a standard part of VHA BRS. They must also be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). No private agency should be used for newly war blinded service members or veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, and joint peer-reviewed vision research.

BLIND REHABILITATION SCHOLARSHIPS

On May 5, 2010, the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law, creating Public Law 111–163. Chapter 75 of this law directs the VA Secretary to establish and carry out a scholarship program to provide financial assistance to individuals who are accepted for enrollment or currently enrolled in a program of study leading to a degree or certification in visual impairment or Orientation and Mobility. The purpose of this scholarship program is to increase the supply of qualified blind rehabilitation specialists for the Department of Veterans Affairs. Since the time of creation of this law, VA has not provided any scholarships for those interested in pursuing a certification or degree in visual impairment and mobility.

CONCLUSION

Once again, Chairman Isakson, Chairman Miller, Ranking Member Brown, Ranking Member Blumenthal, and all Members, thank you most especially for the opportunity to present BVA's legislative priorities before you today. I will now gladly answer any questions you may have concerning our testimony.

RECOMMENDATIONS

- Ensure the full establishment of the Vision Center of Excellence (VCE) and Defense Veterans Eye Injury Registry (DVEIR). DoD/VA staffing resources is critical for future success. We request oversight hearings on the three DoD-VA Centers for Vision, Hearing, and Limb Extremity.
- The dedicated Vision Trauma Research Program (VTRP) should become a line item in DoD's Congressionally Directed Medical Research Program, funding $15 million in FY 2016 defense appropriations.

- BVA requests that the 114th Congress pass H.R. 288 and S. 171, Medical Access to VA Blind Rehabilitation Centers (BRCs). Passage would result in amending Title 38 U.S.C., Section 111.
- Ensure that VA implement full Americans with Disabilities Act Section 508 compliance for all VHA and VBA Information Technology program sites and that VA set timelines, funding levels, and staffing.
- Revisit the issue of ensuring that VHA provide vital medical educational conferences to meet the recruitment, retention, licensure, certification, and professional development standards necessary for a well-qualified VHA workforce. The conferences can be conducted in a cost effective manner that make them well worth the investment of valuable resources.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS BLINDED VETERANS ASSOCIATION

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501(c)3 congressionally chartered nonprofit membership organization.

MARK A. CORNELL BVA NATONAL PRESIDENT

BVA National President Mark A. Cornell was born in Buffalo, New York, and served for nearly 18 years in the United States Air Force. He is a recipient of the Bronze Star and Air Medal for his service in Operation Desert Shield and Operation Desert Storm, performing during his service such duties as Air Force Security Police Specialist, Audio-Visual Television Production Specialist, Aerial Photographer for new test aircraft, and Combat Aerial and Ground Photographer.

While still on active duty and attending Syracuse University to pursue a career in electronic journalism, Mr. Cornell lost his much of sight as a result of a rare reaction to Lyme's Disease caused by a tick bite that went unnoticed.

Mr. Cornell has logged thousands of hours in the BVA volunteer office at the Audie L. Murphy VA Medical Center, where he has represented BVA on both the VA Voluntary Services Committee and on the VA Hospital Directors Service Program. His service also includes direct help to blind and visually impaired veterans through the VA Visual Impairment Service Team at the Medical Center, a role he hopes to keep for as long as he is able.

Mr. Cornell is active in the local Low Vision Club. He was first elected as a BVA District Director in 1999 and went on to hold national office as Treasurer, Secretary, and Vice President. He has also served as both President and Secretary of the South Texas Regional Group. He currently resides in San Antonio, Texas.